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C 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted in your facility on 12/15/08 through 12/18/08. There were 10 inpatients at the time of the survey. Twenty-three records were reviewed. Two complaints were investigated. Complaint #NV00019110 was unsubstantiated. Complaint #NV00020288 was substantiated. (See Tags 295 and 323) The facility was found to be in compliance with all Conditions of Participation. Standard level deficiencies were identified. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified:	C 000		
C 205	485.618(c)(1) BLOOD AND BLOOD PRODUCTS The facility provides, either directly or under arrangement, the following: (1) services for the procurement, safekeeping, and transfusion of blood, including the availability of blood products needed for emergencies on a 24-hours a day basis This STANDARD is not met as evidenced by: Based on a review of laboratory blood bank	C 205		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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C 205	Continued From page 1 department records and an interview with blood bank testing personnel, the facility failed to ensure the safekeeping of blood and the availability of laboratory services by not performing alarm checks on the blood bank refrigerator and freezer containing units of blood and blood products for transfusion purposes, and by the lack of calibration of a serofuge used for the blood bank's backup procedure method. Findings include: 1. According to the blood bank's quarterly alarm check records and an interview with blood bank testing personnel on 12/16/08 at approximately 4:15 PM., no alarm checks were conducted after June of 2008 on the blood bank refrigerator and freezer containing blood and blood products. 2. Blood bank testing personnel, in an interview on 12/16/08 at approximately 4:30 PM., stated that the serofuge used for the blood bank's "tube method" backup procedures had not been calibrated since May of 2007.	C 205		
C 276	485.635(a)(3)(iv) PATIENT CARE POLICIES [The policies include the following:] (iv) rules for the storage, handling, dispensation, and administration of drugs and biologicals. These rules must provide that there is a drug storage area that is administered in accordance with accepted professional principles, that current and accurate records are kept of the receipt and disposition of all scheduled drugs, and that outdated, mislabeled, or otherwise unusable drugs are not available for patient use.	C 276		

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C 276	Continued From page 2 This STANDARD is not met as evidenced by: Based on policy review, record review, and staff interview the facility failed to ensure that an ongoing review of pharmaceutical policies, procedures, and formulary was completed by the Pharmacy and Therapeutics Committee. Findings include: On the morning of 12/15/08, the facility's Policy on Policies was reviewed. Review of this specific policy outlined the establishment of a policy review and approval process for all policies. Under section one of the Policy on Policies identified: "1.3 Each department will have an intradepartmental policy committee that will meet at least quarterly, or more often as necessary, to review and approve new policies and changes to existing policies." Under section two of the policy identified: "2.1 Review and/or revision of implemented policies may take place at any time; however, all policies will be reviewed by the department Policy and Procedure Committee at least annually more often if department needs dictate." On the morning of 12/16/08, the facility's Pharmacy Policies and Procedures were reviewed. The policy and procedure throughout the Pharmacy Policies and Procedures document were dated "Original Date: Feb 2006." Review of the Drug Formulary policy identified the importance of a drug formulary for the effective use of drugs, a sound program of drug usage, to minimize drug duplication and that it was advantageous to the nurse in facilitating safety in the administration of medication to the patient.	C 276		

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C 276	Continued From page 3 The policy outlined that the formulary was established and re-evaluated on a periodic basis by the Pharmacy and Therapeutics Committee. The policy also indicated that requests to change, add or update the formulary were to be reviewed by the Pharmacy and Therapeutics Committee at the committee's regular meetings held every other month. On the morning of 12/17/08, an interview with the Director of Pharmacy revealed that the last meeting held by the Pharmacy and Therapeutics Committee was in August 2007. When the Director of Pharmacy was asked how often the Pharmacy's Policy and Procedures were reviewed and updated the director was not aware of the annual requirement. While pointing to the Feb 2006 date on a policy page in the Pharmacy Policy and Procedures document, the director stated they (the policies) were last reviewed in February of 2006.	C 276		
C 278	485.635(a)(3)(vi) PATIENT CARE POLICIES [The policies include the following:] (vi) a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that employees were tested for tuberculosis and that preemployment physicals were done on employees per facility policies. Findings include:	C 278		

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C 278	Continued From page 4 A review of the personnel files of Employees #1, #2, #3, #4, #5, #6, #9, #10, and #12 revealed there was no evidence of a two-step tuberculin skin test. A review of the personnel files of Employees #1, #2, #3, #4, #5, #9, #10, and #12 revealed there was no evidence of a preemployment physical examination or a statement from a physician indicating the employee was free of communicable disease and in good health. A review of the facility's personnel policies indicated that all employees would receive a preemployment physical examination and a tuberculin skin test. An interview with the infection control nurse revealed that not all employees had received the tuberculin skin tests or physical examinations.	C 278		
C 279	485.635(a)(3)(vii) PATIENT CARE POLICIES [The policies include the following:] (vii) If the CAH furnishes inpatient services, procedures that ensure that the nutritional needs of inpatients are met in accordance with recognized dietary practices and the orders of the practitioner responsible for the care of the patients, and that the requirement of §485.25(i) is met with respect to inpatients receiving posthospital SNF care. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that nutritional consultations for 3 of 23 patients at risk were done and timely. (#3, #5, and #15)	C 279		

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C 279	Continued From page 5 Findings include: Patient #3 was admitted to the facility on 12/11/08 with diagnoses including head laceration and concussion. A review of the physician's orders revealed an order for a nutritional consult. There was no evidence in the record of a nutritional consultation being done. An interview with the director of nursing (DON) revealed the consultation was not done. Patient #5 was admitted to the facility on 12/12/08 with diagnoses including acute pancreatitis, dehydration, and post traumatic stress disorder. A review of the nutritional screening form completed by the nurse revealed that pancreatitis was not listed as high risk disease in need of a nutritional consultation. A conversation with the DON indicated the screening form should include pancreatitis as a high risk illness. There was no evidence a nutritional consult was ordered or done. Patient #15 was admitted to the facility on 12/15/08 with diagnoses including diabetes mellitus with poor control and renal insufficiency. The patient was placed on a 2000 calorie American Diabetic Association diet. There was no evidence of a nutritional screening being done. The DON could not locate the screening form in the record. The consulting dietician was on vacation during the survey and there were no provisions to offer nutritional consultation during her absence.	C 279		
C 283	485.635(b)(3) DIRECT SERVICES Radiology services. Radiology services furnished at the CAH are provided as direct services by	C 283		

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C 283	Continued From page 6 staff qualified under State law, and do not expose CAH patients or staff to radiation hazards. This STANDARD is not met as evidenced by: Based on a review of radiology department policy and procedure manuals and an interview with the radiology department manager, the radiology services provided by the hospital are not assured to be provided in an adequate or safe manner by qualified practitioners. Findings include: 1. An interview on 12/16/08 at approximately 2:00 PM with the radiology department manager revealed that the turnaround time for the interpretation of roentgenograms for the emergency department was unacceptable. The final report and interpretation provided by a contracted radiologist may be provided up to 10 days after the patient's visit to the emergency department. 2. There was no policy in the Radiology department policy and procedure manual which stated who was qualified to read and interpret X-rays. 3. The Nuclear Medicine and CT procedure manuals were not approved by the Department Chief and the medical staff. 4. An interview with the radiology department manager on 12/16/08 at approximately 2:30 PM indicated that there was no written policy for the maintenance and testing of personal radiation devices. 5. According to an interview with the radiology	C 283		

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C 283	Continued From page 7 department manager on 12/16/08 at approximately 3:30 PM, there was no record of shielding (apron) maintenance and testing.	C 283		
C 295	485.635(d)(1) NURSING SERVICES A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure appropriate certifications of nursing staff in accordance with the facility policy, facility job descriptions, and the practice standards for 3 of 13 employees. (#4, #6, #12) Findings include: Review of the employee personnel records revealed that Employee #6 did not have certifications for pediatric advanced life support (PALS) or neonatal resuscitation program (NRP) as specified by the facility's job description. An interview was conducted on 12/16/08 with the Director of Nursing (DON). She stated the surgical services department adheres to the Association of Perioperative Registered Nurses (AORN) standards of practice. Employee #6 did not meet the job qualifications as described in the facility's job description policy or the AORN standards in the areas of experience and expertise.	C 295		

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Employee #6 assumed the position of Surgical Services Manager on 9/18/08. She had no perioperative nursing experience and was being trained to circulate in the operating room during this time. An interview was conducted with Employee #6 on 12/16/08. She confirmed her perioperative experience was limited but had worked pre/post surgical care.

Review of employee personnel records revealed that Employee #12 did not meet the facility's job description qualifications to be practicing in the Post-Anesthesia Care Unit (PACU). The minimum requirement was to have current advanced cardiac life support (ACLS), pediatric advanced life support (PALS), and neonatal resuscitation program (NRP) certifications to care for patients in the post anesthesia care unit. Employee #12 was hired into the PACU and assumed patient care on 8/25/08 without having these requirements met.

An interview was conducted with the DON on 12/16/08. She stated the PACU adheres to the American Society of PeriAnesthesia Nurses standards (ASPAN) and agreed that Employee #12 did not meet the minimum requirements.

An interview was conducted with the Chief Executive Officer (CEO) and Director of Nursing (DON) on 12/17/08. They confirmed that the two surgical nurses did not meet the facility's job descriptions qualifications or the appropriate standards of practice.

Review of the job description for the position of Emergency Department Supervisor - Registered Nurse (Employee #4) under the list of "Essential Accountabilities" revealed the following: Attends

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C 295	Continued From page 9 additional continuing education seminars and conferences to remain current with advanced cardiac life support (ACLS), cardiopulmonary resuscitation (CPR), neonatal advanced life support (NALS), basic life support (BLS), and pediatric life support (PALS) certification. Review of the Emergency Department Supervisor's employee file revealed no evidence that she had a current NALS certification. The Emergency Department supervisor was interviewed on 12/17/08 at 1:30 PM and reported that she was not currently NALS certified.	C 295		
C 298	485.635(d)(4) NURSING SERVICES A nursing care plan must be developed and kept current for each inpatient. This STANDARD is not met as evidenced by: Based on policy and medical record review, and staff interviews the facility failed to ensure nursing care plans identified individual patient's nursing care needs, to keep the care plans current and did not address plans for discharge for 2 out of 23 patients. (#1, #16) Findings include: On the morning of 12/16/08 the facility's Nursing Policy and Procedures were reviewed. Review of the Medical/Surgical Admission Assessment Policy revealed that a patient assessment would be completed by a registered nurse upon admission. The policy specified: "Plan of care is implemented according to need; problem or nursing diagnosis..." The policy further indicated:	C 298		

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"Assessment: A plan of care will be initiated on admission, which will include goals and interventions, and be specific to patient condition and needs."

Review of the facility's Admission Questionnaire, Assessment of Patient at Risk For Falls and Nutritional Risk Screening forms, which are used in the completion of the Medical/Surgical Admission Assessment revealed comprehensive tools for assessing and identifying a patient's condition, needs, and problems. Completion of these documents would assist staff in identifying problems, concerns, needs, and barriers in the development of an individual care plan.

Review of the facility's Interdisciplinary Plan of Care (IPOC) Guidelines revealed sixteen care plan items which outlined goals, interventions, and outcome. The IPOC Guidelines would guide staff in developing a care plan for a patient. There were specific items for Impaired Physical Mobility, Altered Pattern of Elimination (urinary or bowel), and Discharge Planning. The guideline for altered pattern of elimination addressed incontinency and the potential for perineal skin breakdown. The guideline for discharge planning identified that a discharge plan would be addressed on admission.

Patient #1 was admitted via the emergency department to the facility's Medical/Surgical Unit on 8/23/08 with diagnoses of head abrasion, limb pain, deviated nasal septum, hypothyroidism, gout, fall, fatigue and weakness. The patient was later discharged on 8/25/08.

On 12/16/08, Patient #1's medical records were reviewed. Review of the patient's "Patient's

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Assessment Summary" completed on 8/23/08 failed to identify the status of bowel/bladder continence or incontinence.

Review of Patient #1's nursing assistant's documentation, dated from 8/23/08 to the time of discharge on 8/25/08, indicated the patient was incontinent of bowel and bladder making the patient at risk for perineal skin breakdown.

Review of Patient #1's Interdisciplinary Patient Plan of Care failed to address incontinency and the risk of perineal skin breakdown. The care plan also failed to address discharge planning.

Patient #16 was admitted via the out patient operating/recovery room to the facility's Medical/Surgical Unit on 12/9/08 with diagnosis of status post colon resection.

On 12/16/08, Patient #16's medical records were reviewed. Review of the patient's Interdisciplinary Patient Plan of Care failed to reveal a relevant care plan for the patient's condition and needs. A concern for a patient following a colon resection is for the patient to have a bowl movement.

There was a care plan for Patient #16 which identified altered pattern of elimination (bowel) for incontinence. The goal of this particular care plan was for the patient to remain dry, comfortable, and for the perineal skin to remain intact. The care plan also failed to address discharge planning.

On the afternoon of 12/16/08 the facility's Directory of Nursing (DON) was interviewed. The DON stated that in following the facility's policy nursing staff initiate the patient's care plan upon

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C 298	Continued From page 12 admission and that discharge plans are initiated at the time of admission. On the afternoon of 12/17/08 the facility's Medical/Surgical Unit supervisor was interviewed. The supervisor confirmed that the registered nurse was responsible for completing the initial Admission Questionnaire at the time the patient was admitted, that the care plan was initiated at the time of admission and should also include a plan for discharge. The supervisor agreed that the Admission Questionnaire helped the nurse in identifying a patient's needs and concerns and that it was also helpful in developing the patient's care plan along with the IPOC Guidelines. The supervisor confirmed that nursing was responsible to continue to add to the patient's care plan as other needs/condition changes were identified throughout the course of the patient's stay. On 12/17/08, in separate interviews the care plans for Patent's #1 and #16 were reviewed and discussed with the DON and Medical/Surgical Unit supervisor. Both the DON and Medical Surgical Unit supervisor agreed that the care plan for Patient #1 should have addressed the risk of perineal skin breakdown and that the care plan item for bowel elimination, as documented, was not relevant/accurate for Patient #16's condition and needs and confirmed following the facility's policy that both patient's plans should have included a plan for discharge.	C 298		
C 323	485.639(c)(1) ADMINISTRATION OF ANESTHESIA The CAH designates the person who is allowed to administer anesthesia to CAH patients in accordance with its approved policies and	C 323		

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C 323	Continued From page 13 procedures and with State scope of practice laws. (1) Anesthesia must be administered by only - (i) a qualified anesthesiologist; (ii) a doctor of medicine or osteopathy other than an anesthesiologist, including an osteopathic practitioner recognized under section 1101(a)(7) of the Act; (iii) a doctor of dental surgery or dental medicine; (iv) a doctor of podiatric medicine; (v) a certified registered nurse anesthetist (CRNA), as defined in Sec. 410.69(b) of this chapter; (vi) an anesthesiologist's assistant, as defined in Sec. 410.69(b) of this chapter; or (vii) a supervised trainee in an approved educational program, as described in §§413.85 or 413.86 of this chapter. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to comply with approved policies and procedures and with state scope of practice laws for the delivery of anesthesia for 1 of 23 patients. (#12) Findings include: An interview was conducted with the Certified Registered Nurse Anesthetist (CRNA) on 12/16/08. The CRNA stated he did perform an epidural procedure on a laboring patient in severe pain and experiencing hypertension while providing anesthesia to a surgical patient, Patient #12 on 9/3/08. He stated he was in a bind being the only anesthesia provider available and felt he could perform both functions in a safe and efficient manner. He said, "I never lost sight and	C 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 323	Continued From page 14	C 323		

was in hearing distance of Patient #12 at all times and performed the epidural outside the door of the surgical suite." He stated "my surgery patient was totally stable and in a phase of requiring monitoring only." He said "I made everyone in the operating room aware of my intentions and there were no objections from anyone including the surgeon. The epidural took less than 15 minutes."

Review of the facility's policy and procedure on Administration of Anesthesia revealed:

4. Continuous physiological monitoring is expected for all patients undergoing surgical procedures.

9. The anesthesia care provider remains with his/her patient throughout the course of anesthesia and accompanies the patient to the PACU.

A telephone interview was conducted on 12/17/08 at 1:20 PM with the Director of Operations at the State Board of Nursing. The Director stated a CRNA's standard of practice includes "a practitioner should never leave a patient unattended for any reason."

Review of the perioperative record dated 9/2/08 for Patient #12 did not indicate the CRNA left the operating room. Review of the Anesthesia Record dated 9/2/08 for Patient # 12 did not indicate the CRNA left the operating room at any time.

A Physician Progress Note addendum, dictated 10/1/08 by the attending surgeon of Patient #12 revealed, "Please note that during the course of the case, there were at least 5 instances where an anesthesia provider was not apparently present in the room, with only a circulating nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	291311	A. BUILDING _____ B. WING _____	12/18/2008

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C 323	Continued From page 15 present. The patient was stable post-procedure."	C 323		